Your Child's 2 Month Well Visit – What to Expect, What to Ask

Your Name: _____ Your Relationship to the Child:_____
Are there specific concerns you want to discuss today? □ No □ Yes _____

Have there been any major changes in your family lately? □ None □ Move □ Job Change □ Separation □ Divorce
□ Death in the family □ New pet □ Other? Describe: _____

Child lives with? □ Both Parents □ Mother □ Father □ Stepparent □ Grandparent(s) □ Other? _____
Total number of adults living in home: _____ Total number of children living in home: _____

Who takes care of your child most days of the week?
□ Mother □ Father □ Other relative (e.g. grandmother) □ Daycare □ Other? Describe: _____

In general, how well do you feel you are coping with the day-to-day demands of parenthood?
□ Not well at all □ Not very well □ Somewhat well □ Well □ Very well

General Health Information: Since your last visit	**Yes**	**No**	**Unsure**
Have you or your child had any major illness and/or hospitalizations?			
Have you, anyone in your family, or your child's relatives developed new medical problems?			
Does your child have allergies? If yes, describe:			
Does your child take medications regularly? If yes, list here:			
Do you have someone you can trust and go to for emotional support?			
Are yours and your child's immunizations current (includes flu and pneumonia vaccines)?			
Do you or any adults around your child smoke (includes inside or outside the house)?			

Is your child breast or bottle-feed?
□ Breast: Number of feedings in the last 24 hours ____
□ Bottle: Type of formula ____ _____ How many ounces with each feeding? ____

Would you like to get more information on any of the topics below? (please circle)

Injury Prevention	**Health Promotion**	**Nutrition**
• Car safety restraints • Falls, Infant Walker • Burns • Choking management • Sleep position (SIDS) • Passive Smoking • Pool/bath safety	• Immunizations • Thermometer Use, Tylenol • Teething • When to call doctor • Well-child care • Family Planning	• Breastfeeding • No solids until 4 months • Formula preparation • No bottles in bed

Do you have any specific concerns about your child's learning, development or behavior? □ A lot □ A little □ Not at all
Describe: _____

Do you have any concerns about your child's vision (how well your child sees)? □ Yes □ No

Do you have any concerns about your child's hearing? □ Yes □ No

Please check each task your child is able to do right now.

□ Smiles responsively □ Inspects surroundings □ Vocalizes in play □ Lifts head

What to expect at your Child's Texas Health STEPS exam

□ Health History □ Length □ Weight □ Unclothed Physical Exam
□ Head Circumference □ Parent Hearing Checklist □ Immunizations (Rotavirus, DTap, Hib, Pneumococcal, Polio, Hepatitis B)

This is not a self-diagnosis tool or a treatment plan. Please consult with your doctor and share this form at your next visit.